ST. BARTHOLOMEW'S HOSPITAL JOURNAL

VOL LXI OCTOBER 1957 No 10

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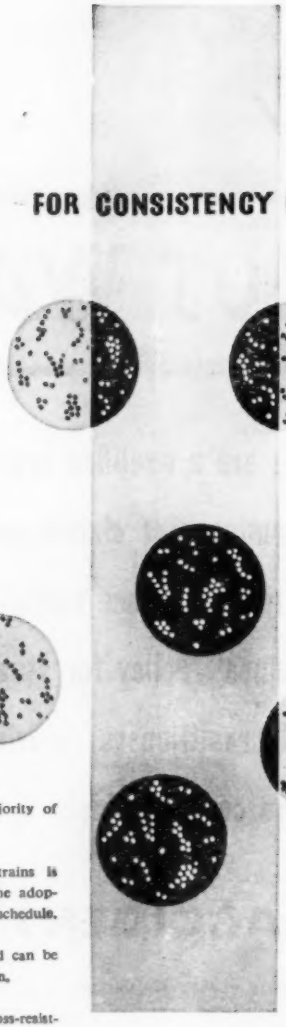
FOR CONSISTENCY OF ACTION AND RESPONSE



". . . there has been relatively little evidence . . . that Staphylococcus aureus *strains are becoming increasingly resistant to chloramphenicol as has been observed with other broad-spectrum antibiotics".*†

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- No significant or regular degree of cross-resistance with other antibiotics occurs.

† Ross S. In Welch's *Principles and Practice of Antibiotic Therapy* N.Y. 1954.

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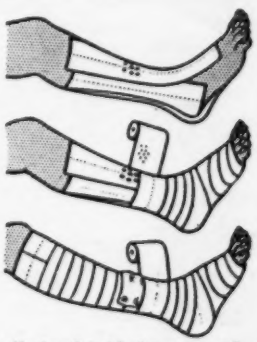

The limb should be covered with vertical strips of Elastoplast bandage. An Elastoplast bandage is applied from a point just below the bend of the knee to the webs of the toes, enclosing the heel. The turns of bandage should overlap one another by at least half or even two-thirds of the width of the bandage to prevent ridging of the skin.

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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EDITORIAL

IN SOME of the following pages of this issue, contemporaries and the newly-qualified may find Dr. Penry Rowland's "*Flashbacks to the 1890's*" anachronistic in substance. The second affirmed object of the *Journal* being "to promote and extend the feeling of *esprit de corps* among students, past and present, in their work, amusements, and matters of interest to them in daily life . . . to give non-active members some idea of the means by which the name of this great Royal Hospital is being maintained, and so, by example, to rouse them into activity"; this gives the lie to their way of thinking. By means of his disconnected jottings and amusing anecdotes drawn from the gas-light, horse-and-buggy era, Dr. Rowland has managed to demonstrate to many of us living in a supposedly more colourful age the fallacy of labelling the Victorian period as "drab" or naturally, "Victorian".

One is given a clear insight of the atmosphere at Bart's during the latter part of the last century. The sound of hooves resounding in the Square, the sight of hansoms drawing up with their bearded and top-hatted passengers, the smell of carbolic pungent in the theatres and wards — all these sensations are conveyed to the reader without the exercise of too much imagination. Our older and non-active readers may derive some pleasure or displeasure from "*Flashbacks*". Certain anecdotes may be remembered with bell-like clarity by some or with aversion by others because unkind reference might have been made of erst-while colleagues.

The *Journal* feels that by publishing "*Flashbacks*", it will be fulfilling not only its second affirmed object but also the important task of providing active members with some idea of the means by which the name of this great Royal Hospital was being maintained. The article might well be considered a historical treatise!

In the August *Journal*, we speculated on the "nature of the machinations of the fifth and sixth floors" of the Surgery Block, The exact nature of at least one such machination is now known. With his "*Some Thoughts on the Present Treatment of Metastatic Breast Cancer*," Mr. G. J. Hadfield has opened the door to the inner sanctum. We would appreciate the co-operation of other dwellers of the fifth and sixth floors and those of the Pathology Building.

The new Surgical Block in Little Britain is rapidly approaching completion. One hopes that the reduction of capital expenditures on building, transport and other essential services occasioned by the increased Bank Rate will have little or no effect on the celerity with which the building is completed or on its final quality. For a closer look at the finished building, our readers are invited to refer to the article written by Mr. W. A. Guttridge of the firm of architects responsible for the design of the building.

With the advent of yet another Rugger season, our mascot "Percy" will be very much in everyone's mind. In our May edition, we asked the forbearance of our readers, promising shortly to "produce an authoritative history" of our "taciturn ambassador of goodwill". Readers of Mr. E. A. J. Alment's biography in this issue will agree that their patience has not been in vain.

We would like to reiterate Mr. Alment's wish that some body of students with a sense of responsibility and service to Bart's will come forward to give this icon of ours a body- and face-lift and to restore it to its deserved place of high esteem and glory. Would our pre-clinical colleagues please take heed? Perhaps yet another top-hatted gentleman will perch himself on top of the rebuilt form of this traditional idol "in all its saturnine, achondroplasic, onychogryphotic glory" when it is borne triumphantly back to Smithfield with the Hospitals' Cup.

* * *

"A New Guide"

The Students' Union is printing a "Students' Union Guide" which will be presented to new students upon their arrival at Bart's. Specific information on the activities of the various clubs in the hospital is provided—this should prove helpful to the newcomer. The desultory visitor or browsing reader will know that in the Library is to be found a copy of the 1923 "Students' Union Year Book" after which the new "Guide" is patterned in part. A limp-covered red pamphlet of about the same size as the College Handbook, the 1923 Year Book contains an alphabetical list of all Bart's men, their addresses and a directory with names arranged under localities. Also included in it are miscellaneous advertisements which defrayed part of printing costs, and an alphabetical list of students at Bart's at that time.

On glancing through the list of students of that day, one comes across many familiar names—H. B. Stallard, J. C. Hogg and N. A. Jory being but a few examples. We believe that a new Year Book containing individual photographs of students in their respective batches will prove invaluable to many, particularly to those interested in physiognomy. At some later date, the physiognomist may be able to confirm with self-satisfaction his own prophecies that young Bloggs did in fact attain consultant status.

* * *

Rahere Music Society

The Rahere Music Society sang an Evensong in St. Paul's Cathedral on Monday, August 26th. The William Smith setting of the responses was sung and the anthem was taken from Bach's 150 Cantata and was sung in German. The Choir sang well on the whole though they found difficulty in breaking with the Parish Church style of singing in the Magnificat. Richard Sinton the conductor is to be congratulated on welding a mass of mainly inexperienced individuals into a united choir at such short notice.

* * *

Revival

Seemingly inspired by the recent successes of the B.R.Ms, certain members of the Student Body have taken steps to revive the moribund Bart's Motor Club. Up till about three years ago, this club had an extremely healthy membership which boasted of a wide variety of machines, from the sportive dash of a brace of old Lagondas to the aristocratic suavity of a Red Label Bentley. With the departure of these gentlemen from the gates of their Alma Mater, the Motor Club went into abeyance as did all those frequently delightful visits to the more secluded hostelries in the Home Counties which were carried out on the excuse of 'rallying'.

The movement afoot to resuscitate the activities of the Motor Club laudable though it may be, invites further comment. In the course of their development, young men and even medical students are known to identify themselves with various occupations —the rôles of engine-driver, postman or Stirling Moss are well-known ones. In such places as the Refectory or the Abernethian Room, it is altogether too common an experience for one to be an unwilling audience in a charivari of an assertive and often inaccurate nature during which compression ratios, performance figures and road-holding characteristics are rattled off by "knowledgeable" gentlemen.

Zeal and genuine interest are healthy signs in any undertaking or hobby but the caveat is entered here that they should not be confused with fanaticism.

Although the prospective members who have put down their names for the Motor Club seem to be more in need of real motors than of a club in which to put them, it is hoped that more positive support will come with the passage of time. Perhaps members of the Staff and even the pre-clinical years will provide the required "driving force".

Rugby Football

With the approach of the new 1957-58 season, many stiff bodies can be seen limbering up both at Chislehurst and at Basketball in Charterhouse Square. After last year's highly successful runs in the Hospitals' Cup and in the Middlesex Seven-a-sides, it is hoped that the coming season will be approached with a new spirit of keenness and enthusiasm by all the present members of the Club and by new members coming to the Hospital in October.

It was indeed a great pity to see such stalwarts as John Tallack, David Roche and Mickey Davies hang up their boots at the end of last season and we shall have to play particularly well in the forwards to make up for the loss of that very experienced and strong second row of Tallack and Roche. We have also been unfortunate to have lost Howard Thomas, the ubiquitous and intelligent wing forward who played such an important part in our Cup successes.

The new captain, R. M. Phillips, who has just returned from his third overseas rugby tour this year during which he played for Llanelly in the International Youth Festival in Moscow, will need the support and co-operation of both old and new members if he is to continue the good work of his predecessors The strength of the fixture list has gradually been increased and this season shows the welcome return of the Metropolitan Police after a lapse of two seasons. We are, however, sorry to lose Paignton at the end of the Cornish Tour. The deletion of this match was due to their inability to pay the guarantee they have offered us in past years. However, two new fixtures have been arranged at the end of the season—one against Treorchy, with whom we had such a good game last season and another against Tredegar.

In the Hospitals' Cup, we have been drawn against St. Thomas's, followed by our Cup-final opponents of last year, the London Hospital. The 1st round Cup Tie is on Tuesday, January 14th and it is to be hoped that the 1st XV will again receive the same encouragement and wonderful support it received during its Cup run last year.

Members of the Club are kindly requested by the Secretary to tick off their names as soon as lists of teams appear, as this will be of great assistance to him in the smooth running of four or five teams.

NOTICE

The Boat Club Dinner will be held on Wednesday, November 27, after the United Hospitals Winter Regatta.

ANNOUNCEMENTS

Engagement

KIELTY—SPENCER.—The engagement is announced between Dr. Michael Gerard Kielty and Patricia Mary Spencer, S.R.N., S.C.M.

Marriage

DAWSON-RACKHAM.—On St. Bartholomew's Day, John Bernard Dawson to Gillian Mary Rackham.

Births

CHONG.—On October 5th, at Bart's, to Junie and Kenneth Chong, a daughter (Lavinia Karen).

CLIFFORD.—On August 4, at Imtanfa, Malta, to Jean (*née* Murray) and Major W. E. Clifford, a daughter.

GRAHAM.—On August 1, to Christine, wife of Dr. Malcolm Graham, a daughter.

GRANDAGE.—On August 10, to Sybil, wife of Dr. Christopher Grandage, a son.

HAIGH.—On August 13, to Sanda and Dr. Adrian Haigh, a son (Andrew Adrian), a brother for Joanna and Amanda.

HARLAND.—On August 9, to Norah and David Harland, a daughter (Jane Elizabeth Norah).

HOLLAND.—On August 11, to Jean, wife of Dr. H. W. Holland, a daughter.

LONSDALE.—On July 22, to Adele, wife of Dr. D. Lonsdale, a daughter (Susan Margaret), a sister for David and Michael.

MIDDLETON.—On August 22, to Jeanne and Dr. George Middleton, a son.

ROUALLE.—On July 22, to Molly, wife of Dr. Henri Roualle, a son (Michael).

SMITH.—On August 13, to Barbara and Dr. W. H. Roderick Smith, a daughter (Phillippa Loiuse Roderick).

RANDALL.—On August 3, at the Women's Hospital, New York City, U.S.A., to Dr. and Mrs. J. Randall, a daughter (Suzanne Cristine).

Deaths

COZENS.—On August 17, Frederick Cyril Cozens, aged 65. Qualified 1921.

DRURY.—On August 10, in Nairobi, Kenya, Graham Dru Drury. Qualified 1924.

EDWARDS.—On July 26, John Alwyn Edwards, aged 56. Qualified 1927.

GORDON.—On July 24, Francis Jarvis Gordon, aged 76. Qualified 1909.

RECORDON.—On August 23, Esmond Gareth Recordon, aged 53. Qualified 1928.

* * *

OBITUARY

Esmond Gareth Recordon

The death of Esmond Gareth Recordon at the early age of 53 is a tragedy for his family, his friends and the profession which he has served so faithfully. After graduating at Cambridge he entered St. Bartholomew's Hospital and later became House-surgeon to the Eye department. On leaving Bart's he was appointed to the Resident Staff at Moorfields Eye Hospital where intense and valuable training as an eye surgeon equipped him to gain an appointment to the Honorary Staff of Addenbrooke's, Cambridge. The serenity of Cambridge with its manifold cultural pursuits suited him well for he loved music, literature and art.

Before the war he served in the R.A.M.C. Territorial Army and went to France with the General Hospital recruited in Cambridge. After the military evacuation of France he returned to the United Kingdom. There followed the misfortune of ill health which prevented him from further service abroad.

Esmond Recordon will be remembered for the warmth of his friendship, for his loyalty and the genuine interest he showed so constantly in his friends, colleagues and patients. Among his many admirable human qualities stand out his infinite patience and gentleness in thought and deed. Trained more as a physician than a surgeon he brought to his specialty a wide and philosophic approach. His surgical technique was marked by conservatism and infinite care, and his contributions to the literature were of clinical and practical value.

Our sympathy is for his widow and two sons in their tragic loss.

H. B. STALLARD.

CALENDAR

Thur.	Oct.	3	Abernethian Society Meeting. Speaker: Prof. Sir James Paterson Ross. The Great Hall at 4.45 p.m.
Sat.	,,	5	Dr. A. W. Spence and Mr. C. Naunton Morgan on duty. Anaesthetist: Mr. R. A. Bowen. Hockey: 1st XI Trials. Soccer: v. Old Parkonians (A).
Wed.	,,	9	Golf: Autumn Meeting, Girling Ball Cup (High Moor Park). Soccer: Trials. Hockey: Trials.
Thur.	,,	10	Soccer: Cambridge Tour.
Sat.	,,	12	Dr. R. Bodley Scott and Mr. R. S. Corbett on duty. Anaesthetist: Mr. R. W. Ballantine. Hockey: v. City of London College (H).
Wed.	,,	16	Hockey: v. Imperial College (H).
Sat.	,,	19	Dr. E. R. Cullinan and Mr. J. P. Hosford on duty. Anaesthetist: Mr. C. E. Langton Hewer. Hockey: v. R.N.C. Greenwich (A). Soccer: v. Westminster Hospital (H).
Wed.	,,	23	Hockey: U.H.H.C. v. Essex 'A' (H). Soccer: v. St. Mary's Hospital I. (A).
Thur.	,,	24	Abernethian Society Meeting. Speaker: Mr. Malcolm Donaldson, Physiology Theatre, Charterhouse, at 5.45 p.m. Golf: Annual General Meeting.
Sat.	,,	26	Medical and Surgical Professorial Units on duty. Anaesthetist: Mr. G. H. Ellis. Hockey: v. Tulse Hill Wanderers (H). Soccer: v. Caledonians (H).
Sun.	,,	27	U.H.H.C. v. Surrey 'A' (H).
Wed.	,,	30	Soccer: v. Normandy Company Sandhurst (H).
Thu.	,,	31	Hockey: Cambridge Tour.
Sat.	Nov.	2	Dr. G. Bourne and Mr. J. B. Hume on duty. Anaesthetist: Mr. F. T. Evans. Soccer: v. Swiss Mercantile College (H).
Wed.	,,	6	Hockey: v. Kingston Grammar School (A). Soccer: v. London Hospital I. (H).

LETTERS TO THE EDITOR

PARSLEY FOR PROSTATE

Sir,—Enclosed is an interesting recipe* upon which some of your readers may wish to comment.

The original was given to my grandfather by his former nurse. She was certainly at one time a wife, and old, but my relative knows—from first-hand experience—of about forty aging gentleman, in whom 'the pitcher be broken at the fountain' (*Ecclesiastes XII*, 6). who have benefited from the use of this parsley remedy.

What, one wonders, is the therapeutic action of parsley? Pearl barley is known to be a slight emollient, but has it perhaps some specific effect on the prostate gland?

It is not claimed that this treatment can cause the atrophy of an already enlarged prostate, but that, if taken when the first symptoms appear, the condition will become no worse.

Parsley may be grown at any time of the year, I know, but can anyone offer advice as to which stimulants I should avoid?

Yours sincerely,

DAVID S. WRIGHT.

Abernethian Room.

**Take a good handful of parsley, wash it well, put a pint of cold water in a saucepan, add the parsley, put on the lid and boil for half an hour or more at discretion. The saucepan must be sound, without any flaw in the enamel. Strain well once or twice.*

Dose—*A wine-glass nice and warm every hour until relief comes. This involves, at first, continued making.*

Drink plenty of milk and barley-water—made with pearl barley—but towards evening drop it so as to quieten the action of the stomach. Bovril and fresh beef tea until solids can be taken. Keep off sugar and all sweets, stimulants, fruits, and be very sparing of salt.

CAMBRIDGE — BART'S CLUB

Sir,—More than eighty years ago, in 1876, the Cambridge Graduates Club of St. Bartholomew's Hospital was formed "with a view to establish an annual supper in the winter session in order that those members of the University already at the Hospital might have an opportunity of making the acquaintance of the new-comers." Ever since, except for war-time interruptions, the Club has annually held a gathering for the purpose.

On Friday, 25th October, the Club will hold a Sherry Party in the Library from 6 to 8 p.m., at which Sir Henry Dale, O.M., will preside. We would be grateful if any Bart's Cambridge graduate in this country who may not have received an invitation will let us know as soon as possible.

Yours sincerely,

H. J. BURROWS,
R. A. SHOOTER,
NERYS DAVIES,
Honorary Secretaries.

RECENT ADDITIONS TO THE LIBRARY

ABRAHAMS, Sir Adolphe. *The human machine*, 1956.

AMOS, J. A. S. *Observations on acute diarrhoea of warm climates*, 1957.

ANDERSON, W. A. D. *Synopsis of pathology*. 4*th ed.*, 1957.

BETT, W. R. *Guide to the literature of William Harvey*, 1957.

BRITISH JOURNAL OF CLINICAL PRACTICE. *Spot diagnosis. Vol.* 3, 1957.

BURN, J. H. *Principles of therapeutics*, 1957.

CHAUVOIS, L. *William Harvey*, 1957.

DAVIS, D. R. *Introduction to psycho-pathology*, 1957.

DORLAND'S *Illustrated medical dictionary*. 23*rd ed.*, 1957.

FIELD, E. J. and HARRISON, R. J. *Anatomical terms: their origin*, 1957.

GEIGY, LTD. *Scientific tables*, 1956.

GRAY, T. Cecil. *Reflections on circulatory control*, 1957.

HEWER, C. Langton, and LEE, J. A. *Recent advances in anaesthesia and analgesia*. 8*th ed.*, 1957.

JOHNSON, D. McI. and DODDS, N. *The plea for the silent*, 1957.

LE QUESNE, L. P. *Fluid balance in surgical practice*. 2*nd ed.*, 1957.

MCGREGOR, A. Lee. *Synopsis of regional anatomy*, 1957.

MASON, A. Stuart. *Introduction to clinical endocrinology*, 1957.

M. R. C. Report 295. *Leukaemia and aplastic anaemia*, 1957.

NEWMAN, C. *The evolution of medical education in the nineteenth century*, 1957.

OGILVIE, A. G. and NEWELL, D. J. *Chronic bronchitis in Newcastle-upon-Tyne*, 1957.

OLIVER, J. O. *Aids to pathology*. 11*th ed.*, 1957.

PAGET, C. J. and PAGET, James. *Sketch of the natural history of Yarmouth*, 1834.

RICKHAM, P. R. *Metabolic response to neonatal surgery*, 1957.

ROSEN, G. *The history of miners' disease*, 1943.

ROSS, Sir Ronald. *Four photographs of*.

TREVES, Sir F. *Surgical and applied anatomy*. 13*th ed.*, 1957.

WALKER, Kenneth. *Patients and doctors*, 1957.

YOUNG, J. Z. *Life of mammals*, 1957.

THINKING ABOUT THE FUTURE

A notice of a proposed survey of the aims and ambitions of Bart's medical students

IS THE FOLLOWING scene quite unfamiliar to you? The stage is set at a flagging party, you twirl your cider cup hopelessly — suddenly, a gambit opens from your right. . . .

Limp female: Do you work in the city, Mr. Speakhard?

You: No, actually, I don't.

L.F.: Tell me then what do you do?

You: Oh well, I'm a doct. . . . I mean, a medical student.

L.F.: But how exciting (yawns) — what hospital are you at?

You: Bart's, actually — you know, the one near the meat market.

L.F.: Have you done your midder yet?

You: No.

L.F.: When you qualify, are you going to specialise, or something?

You: Yes, I'm going to be a trichologist. I've already arranged a resident job in a monastery on one of the Scilly Isles.

L.F.: Really? (Drifts away.)

You are a fortunate man if the answer is "No". You may be more honest than the worthy Speakhard, or perhaps have a more ingenious counter-gambit. But it is a certain bet that you know your lines off by heart. It's a play which is having a very long run.

Next month, in a questionnaire sponsored by the *Journal*, you are going to be asked this infuriating question and many others. But unlike the limp female of party fame, we really want to know the answer. The object is to build up a picture of the ambitions of medical students at various stages of their careers. The results of the survey are to be published in the *Journal*, together, we hope, with a picture of what old Bart's men at the moment are doing, so that dreams can be compared with reality.

Another line to be followed is that of emigration. There was a great interest among our readers in the series of articles we published recently by doctors from abroad. Is it the National Health Service, the economic situation, the Registrar bulge, or a resurgence of pioneering spirit that is directing people's eyes over the seas? To this question, as to some of the others, you may not be able to give a definite answer. But in this survey it is ambitions and ideas that we are looking for. The facts will come later.

Questionnaires have become associated in people's minds with intimate questions about their private lives. But this is to be no Kinsey Report. However interesting and even entertaining the private activities of medical students may be, we are content to leave them as one of the great unknowns of social history.

We can give yet another word of reassurance. The completed questionnaire forms will remain completely anonymous. They will be passed unopened to people outside the Hospital for analysis, and the published results will be entirely statistical.

We therefore feel justified in asking you to give careful thought to, and be honest about your answers. If so, the information we obtain should be of great interest, most of all to those who answer the questions. It is, so far as we know, the first investigation of its kind to be conducted. Its success depends largely on you.

SUICIDE WITH A CROCHET HOOK

by TREVOR H. HOWELL

IN A HOSPITAL for the aged sick, there may be found two groups of patients. One of these has been reluctant to leave home and is anxious to return there at the earliest opportunity. The other dreads discharge and wants to stay in hospital as long as possible. The reaction of one of these groups on the other may sometimes have unexpected consequences.

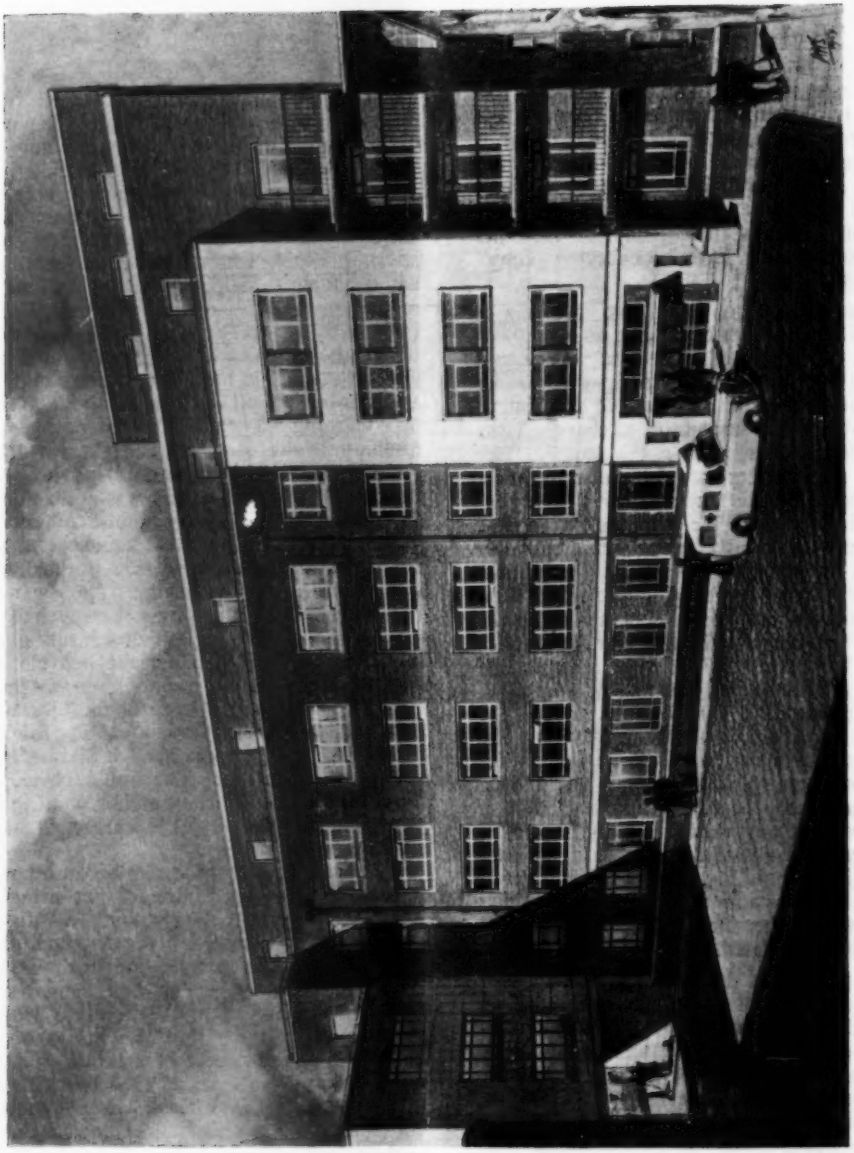
A few years ago, I had two members of each of these groups occupying adjacent beds in one of my wards. The first was an old woman with an arteriosclerotic ulcer on her leg. She lived alone and disliked any kind of interference with her affairs, so that the visits of a district nurse were not welcomed. Her doctor referred her to me because the ulcer had become septic and he feared that gangrene might ensue. We admitted her and the leg improved greatly under treatment. But just as it was healing nicely, the patient insisted upon discharging herself. Two months later, her doctor sent her up to the out-patient clinic with the ulcer septic once more. We again admitted her, and again she discharged herself as soon as it started to heal. Eventually, I was asked to see the patient on a domiciliary consultation. She was evidently a very house-proud woman, for her home was spick and span. But her leg had been sadly neglected and was now so inflamed that amputation might have to be considered. I persuaded her to come into hospital yet again for treatment; and determined that once admitted, we would keep her in bed until either the ulcer healed or the leg had been amputated.

The patient in the next bed belonged to the other group of old people. She suffered from advanced rheumatoid arthritis and was more or less crippled. We had admitted her from the local workhouse (or Public Assistance Institution, as it is now called), because I hoped to rehabilitate her successfully. At first she was grateful for the treatment. But, after a time, she realised that other patients with her complaint were discharged from hospital as soon as they had improved enough to look after themselves. This did not suit her at all. She tried her best to find new complaints and additional pains. This, of course, only resulted in extra treatment and more attention from doctors, nurses and physiotherapists who urged her onwards. She hated having to help herself and the idea of regular remedial exercises was anathema. Eventually she had an idea. The patient next to her (the woman who had the ulcerated leg) was kept firmly in bed. If only she could get an ulcer herself, all this trouble about getting up, learning to walk and preparing for discharge would stop. So, at night, when the ward was quiet, she scratched her leg with her crochet hook until there was quite a deep sore. As a result, the house physician allowed her to be excused attendance at the hated remedial exercise class. Gratified, she went on with the scratching. The leg now became inflamed and physiotherapy had to stop. Unfortunately, an observant night nurse saw her creep under the bed clothes with the crochet hook, and took it away from her. By morning, the knee of the ulcerated leg was hot, swollen and painful. The following day she had a pain in her side and became very short of breath. The house physician put a needle into her chest and drew off thick pus—but she was too ill to care what happened to her now.

I carried out a post mortem because I was interested in the condition of her arthritic joints. Her carpal bones were all fused together on each side. There was much destruction of the soft tissues and ligaments in the right shoulder, which had caused the upward subluxation of the humerus which we had seen during life. The hips showed only a moderate degree of arthritic change. Other joints were little affected by rheumatoid disease. In fact, there was no reason why she could not ultimately have become fairly active and independent as the result of treatment What had interfered with our programme was an infected ulcer of the leg, septic phlebitis, septic arthritis of one knee, empyema and septic pericarditis, which were due to a self-inflicted wound.

Dr. Trevor Henry Howell.

Dr. Howell, M.R.C.P., Ed., is lecturer in the Problems of Old Age at Bart's. He is the author of many papers and books on Geriatrics.



An artist's impression of the new Surgical In-Patients' Block in Little Britain.

THE NEW SURGICAL IN-PATIENTS' BLOCK IN LITTLE BRITAIN

by W. A. GUTTRIDGE

IN 1950 the Hospital commissioned my firm to design a new Surgical Block to contain about 120 beds with associated Operating Theatre Suite, X-Ray Department and other ancillaries. The site consisted of an area of about half an acre adjacent to the Church of St. Bartholomew the Great, and was covered with bomb-damaged properties and some noisome workshops carrying on trades associated with Smithfield Market, such as sausage-skin manufacture. The north-east side of the site was bounded by the remaining wing of the Church Cloisters and it was obvious that the site coincided with the old Cloister Garth. Therefore the principle was adopted of opening up the Garth and planning the building along its south-western and south-eastern boundaries, hence the L-shaped plan which gives the building its popular name of 'L-shaped Block'.

The height of the building was limited by daylighting angles in the surrounding streets and also the desire not to overwhelm the adjacent ancient Church. Further complications were the limitations of the total floor area to five times the site area, the requirement of a new connection under the building between Little Britain and Bartholomew Close, and the rebuilding of 57, West Smithfield in a similar character to what previously existed on that site.

All these facts are given to enable the reader to appreciate that the external form of the building (known as the 'envelope' to architects) was decided by the Town Planning conditions rather than by the Hospital's internal requirements. In short, the architects were presented with a predetermined shape into which the accommodation had to be fitted; a condition which I may say usually applies to City buildings!

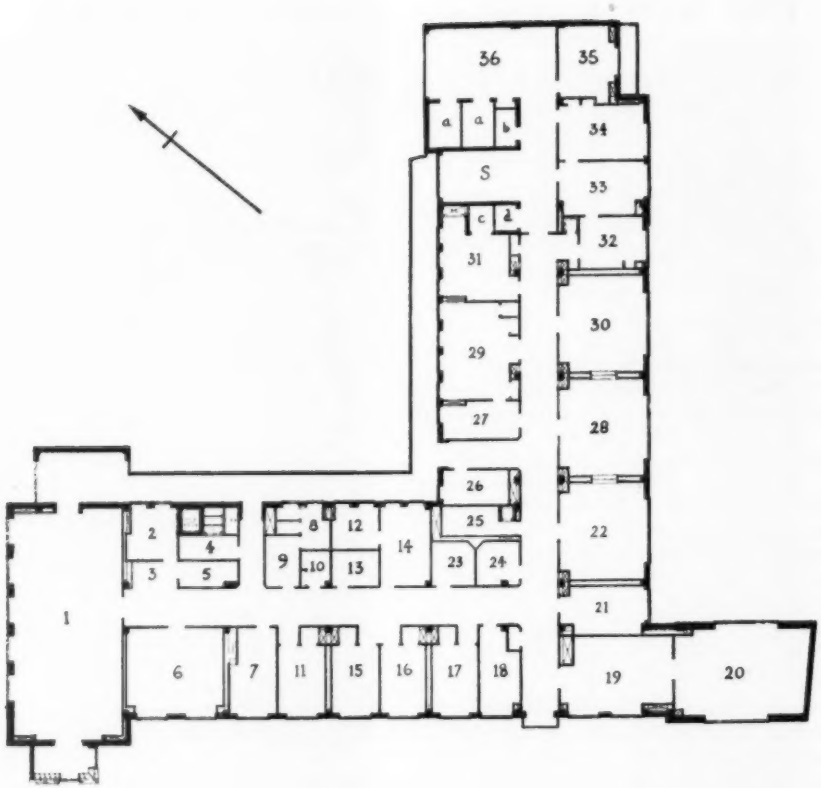
The Internal Planning Generally. A factor which had a fundamental effect on the internal lay-out was the necessity to provide for a possible future wing on the north-east side of Bartholomew Close to give four ward units thus eventually making the building a Z-shaped block. It is mainly for this reason that the main entrance, lifts and staircase are placed at the end of one of the wings of the building and not in the centre of the block.

The final allocation of the floors is as follows:—

Basement: Boiler House and Plant Rooms, Lecture Theatre to seat 180.
Ground Floor: X-Ray Department, Administration.
First Floor: Ophthalmic Ward Unit and associated Operating Theatre suite.
Second Floor: E.N.T. Ward Unit.
Third Floor: Thoracic Ward Unit.
Fourth Floor: Neurosurgical Ward Unit.
Fifth Floor: Twin Operating Theatre Suite with special Skull X-ray Unit attached. Main Kitchen.

A considerable alteration to the Basement plan was made after commencement of work due to a later Ministry of Health requirement that the Boiler House should serve not only the new building but the whole of the existing Hospital. This called for drastic revision of the basement plan and some extension outwards below ground level to enlarge the boiler house as much as possible, but it was fortunately found practicable to retain the large Lecture Theatre.

From the Basement a tunnel runs under Little Britain to connect the new building to the existing Hospital. This tunnel will run behind the East Wing and will connect the Children's Block, East Wing and Nurses' Home with the Medical Block, which is already connected by underground passages with the West Wing and Central Kitchen, Dispensary and Out-Patients' Block. Thus it will at last be possible to eliminate the transportation of patients, food and stores in the open from block to block. The tunnel will, of course, also be available for personnel, who will no doubt find it useful in inclement weather. It will serve as the route



Second Floor Plan

Ear, Nose and Throat Departments

1. *10-Bed Ward*
2. *Sterilising Duty Room*
3. *Nurses' Station*
4. *Dirty Linen*
5. *Medicines Recess*
6. *4-Bed Ward*
7. *Sluice Room*
8. *Staff Lavatory*
9. *Lockers*
10. *H.M.C.*
11. *1-Bed Ward*
12. *Bathroom*
13. *Patients' Clothes*
14. *Women Patients' Lavatory*
15. *1-Bed Ward*
16. *1-Bed Ward*
17. *1-Bed Ward*
18. *General Store Room*
19. *Day Room*
20. *Loggia*
21. *Flower Room and Laboratory*
22. *4-Bed Ward*
23. *Bathroom*
24. *Bathroom*
25. *Clean Linen*
26. *Men Patients' Lavatory*
27. *Sterilising Room*
28. *4-Bed Ward*
29. *Demonstration Room*
30. *4-Bed Ward*
31. *Ward Kitchen*
32. *Subsidiary Sluice Room*
33. *Doctors' Room*
34. *Registrars' Room*
35. *Sisters' Room*
36. *Lift Hall.*

a. *Passenger and Bed Lifts*
b. *Passenger Lift*
c. *Goods Lift*
d. *Rubbish Lift*
S. *Stairs*

for steam mains from the new Boiler House to the distribution points known as Calorifier Rooms in the existing buildings.

The Ground Floor contains a diagnostic X-ray unit having three radiography rooms, but information is not yet available on the precise type of equipment to be used. Its other principal features are an attractive suite of two bedrooms with bathrooms for patients' relatives who have to spend the night at the Hospital, and a large central Patients' Library for the whole Hospital.

The upper floors are best described under their uses.

The Ward Units, 1st-4th Floors. The most important requirement in highly specialised ward units is that the unit should accommodate both sexes, and that a high degree of flexibility in the numbers of each sex to be accommodated should be achieved. This is done by providing smaller wards together with the appropriate lavatory accommodation. The final sizes decided upon for the units in this block were one 10-bed ward, four 4-bed wards and four single-bed wards. In each unit three W.C.'s, three washing cubicles and one special bathroom are provided for women, and two W.C.'s and two wash-basins for men with two unallocated bathrooms. Thus it will be seen that while the 10-bed ward must obviously be used for one sex, the remaining 20 beds in smaller rooms allow for considerable variation in the numbers of each sex accommodated. If the preponderance of men in a unit becomes very great, the allocation of the lavatories can be switched. This plan is known rather inelegantly as the bi-sexual ward unit.

A further advantage of the 4-bed ward is its 'semi-privacy' for the patient and for this reason it is almost universally used in the United States and widely used on the Continent. It obviously creates nursing problems and in the L-shaped block a compromise has been made by glazing the wall between the wards and the corridor so that easy supervision is possible, but curtains are necessarily provided for private occasions.

The ward kitchen is at the entrance to the unit and has a special food lift large enough to take a food trolley serving it direct from the main kitchen on the top floor.

Also near the entrance to the unit is the traditional Sisters' Sitting Room which is a special requirement of St. Bartholomew's Hospital. Then come the treatment units planned individually on each floor to the requirements of the Heads of Departments, but attached to them is a fully equipped sterilizing room which can also serve the wards.

In accordance with modern practice two sluice rooms are provided, one at each end of the unit in order to minimise the carrying of bed-pans, etc. It is assumed that a high proportion of patients will be ambulant, hence the very adequate lavatory accommodation described above, which is generously planned to facilitate the use of 'sani-chairs'.

Another innovation is the Nurses' Station near the entrance to the 10-bed ward, which is a central reporting point for the Ward Unit where telephones and call system control are sited as well as patients' records. Adjacent to the Nurses' Station are the Ward Duty Room including one of the sets of sterilizing equipment and a recess for the storage and preparation of medicine doses, syringes and so on.

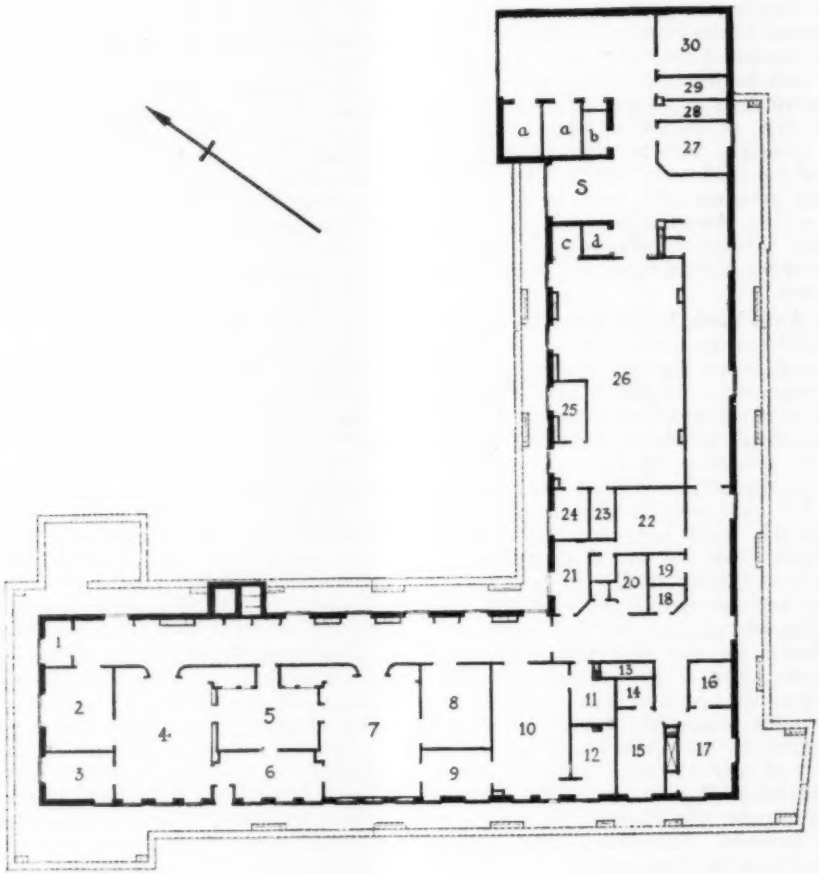
Finally four items which are often either forgotten or squeezed into inadequate corners are here provided on an ample scale, namely Staff Lavatory and Cloaks, Patients' Clothes Store, Ward Store and a combined Flower Room and Test Laboratory.

Operating Theatre Suite—5th Floor. This is a twin-theatre unit which is new to Bart's whose existing theatres are all single units. The twin-theatre arrangement is adopted mainly for reasons of economy as it consists basically of two theatres with one Wash-up and one Sterilizing Room only between them which serve both theatres. Each theatre has its own Anaesthetic Room and Scrub-up, and the latter is approached via the theatre in contrast to those of your existing theatres where elaborate circulation arrangements are made to avoid that happening. The original plan had small corridors allowing access to the Scrub-ups from the main corridor, but these were cut out because of the shortage of floor space.

A special skull X-ray room, complete with wet viewing room and dark room, is provided adjacent to one of the theatres for use during neurosurgical operations and direct access to it is provided from one of the theatres.

The usual changing and ancillary rooms are provided, not the least important of which is a well equipped tea pantry!

The operation suite will be fully air-conditioned and a new complication is introduced by the necessity to reduce the air



Fifth Floor Plan

Theatres and Kitchen

1. *Store Room*
2. *Anaesthetic Room*
3. *Scrub-Up*
4. *Operating Theatre*
5. *Sterilising Room*
6. *Wash-Up*
7. *Operating Theatre*
8. *Anaesthetic Room*
9. *Scrub-Up*
10. *X-ray Room*
11. *Wet-Viewing Room*
12. *Dark Room*
13. *Cupboard*
14. *Lavatory*
15. *Students' Changing Room*
16. *Lavatory*
17. *Surgeons' Changing Room*
18. *Store Room*
19. *Pantry*
20. *Clean Drums*
21. *Sisters' Room*
22. *Nurses' Changing Room*
23. *Dry Store*
24. *Larder*
25. *Office*
26. *Main Kitchen*
27. *Kitchen Staff Room*
28. *Toilets*
29. *Toilets*
30. *Theatre Orderlies*

a. *Passenger and Bed Lifts*
b. *Passenger Lift*
c. *Goods Lift.*
d. *Rubbish Lift*
S. *Stairs*

temperature around the patient to a low level during hypothermia. This creates considerable air circulation problems which are still being studied and will probably only be solved empirically, if, indeed, they are not insoluble. An interesting by-product of air-conditioning is the need to keep the volume of the theatre suite to a minimum to minimise both capital and maintenance costs. Consequently the height of the ceiling is brought down to 10 feet which is considerably lower than in your existing theatres. The writer has seen new theatres in the United States and Scandinavia as low as 7 ft. 6 ins. with a small dome over the table to accommodate the theatre light.

The Main Kitchen — 5th Floor. This calls for little comment except to point out that it is designed to cook prepared food only. It is proposed that all preparation of food, e.g., peeling potatoes, cutting meat, filletting fish and so on shall be done in the Central Kitchen. This obviously minimises the size of the kitchen as well as economising in equipment and staff, while still giving the patient the advantage of meals freshly cooked on the premises.

Mechanical Services. As already stated the building contains a boiler house to serve the entire Hospital and has four tubeless steam boilers which supply steam to Calorifier Rooms at various strategic points where it is used to heat the water for space heating and domestic use. Space heating is by means of embedded low temperature water coils embedded in ceilings, usually known as " Panel Heating," and is similar to that in the King George V Block.

Full air-conditioning is provided in the Operating Theatre suites, and simple plenum ventilation in the X-ray Unit on the Ground Floor and internal rooms which must have mechanical ventilation. The wards themselves rely on natural ventilation as is usual in this country.

A piped vacuum cleaning installation is provided with a central collection point in the basement. The cleaner is simply plugged to a suction point in the corridor and the noise of electric vacuum cleaners is avoided as well as the possibility of fine dust particles spraying into the rooms.

Anaesthetic gases are piped from the central unit in the existing Surgical Block to the Operating Suites and oxygen points are provided to every four beds.

Two high-speed bed lifts are provided with collective control, which means that when the landing button is pressed the first lift to reach that landing stops for the caller. This eliminates the annoyance of waiting at a lift landing and seeing one lift flash past after calling the other lift. There is also a high speed lift for personnel.

There are two hoists for clean and dirty material. The clean hoist delivers direct to the main operating suite from a drum-sterilizing plant and theatre workroom in the basement. The dirty hoist serves each floor and is sited near the treatment units for easy disposal of soiled dressings, etc.

Internal Finishes. Floor finishes fall into four main categories, battleship linoleum in corridors, lift halls and X-ray rooms, hardwood block in wards and offices, terrazzo in treatment and operating theatre suites and buff quarry tiles in lavatories and main kitchen.

Wall finishes are in Keenes cement with glazed tiles in lavatories, treatment rooms, service rooms, main kitchen and operating suites, excepting the theatres themselves which will have terrazzo walls.

Ceilings are plastered in soft plaster to a special specification because of the ceiling panel heating.

In wards and corridors a frieze of acoustic tiles is produced to cut down air-borne noise.

External Finishes. The external facing of the building is a hand-made, sand-faced russet brown brick, but two principal features are faced in Portland Stone ; these are the main entrance bay, and the bay over the roadway connecting Little Britain and Bartholomew Close.

These traditional materials are selected because the building is designed to last indefinitely and not for an amortization period or period of comparatively short lease, as are so many office and flat blocks. The curtain walling or cladding used on many new City building has several drawbacks apart from doubtful length of life and these have been set out in recent circulars by the Building Research Station. They include water penetration, cracking due to thermal movement and " Aeolian-harp " effects due to joints admitting air at high velocity during gales ! These factors, added to the fact that large glass areas are not required in an acute sick hospital, ruled out the use of these techniques. In short, the building is designed for function first and last and I hope that in use it may justify that aim.

PERCY—AN ICONOLOGY

by E. A. J. ALMENT

DURING THE PAST eighteen months various references to Percy have been made in Editorial columns of this JOURNAL. There seems a risk that the precise antecedents of this Bart's mascot may be passing into oblivion. Hence the following facts of his early life have been collected and recorded.

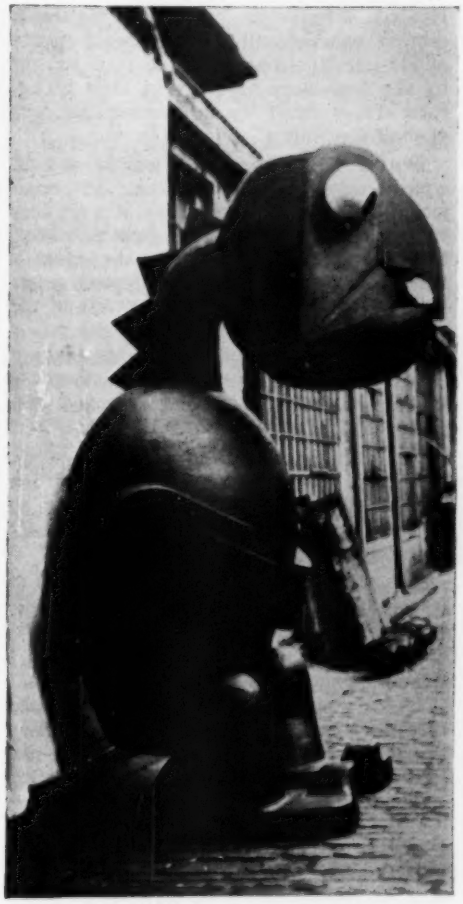
Percy was created by the building firm of Dove Brothers, long associated with the Hospital, as their contribution to the St. Bartholomew's Fair held in the Square in July, 1939. He was designed by an artist named Barney Seale and was constructed of laminated soft timber. Over eight feet high, ten feet in girth, with hands and feet thirty inches long, this woebegone monster was introduced to the Fair as "The Germ of Depression". Standing outside the Steward's Office, he suffered 3-inch iron nails to be hammered into his abdomen at 3d. a time. If the nail could be driven right home in three blows a prize of one shilling was the reward. Such was the quality of Percy's parietes that this feat was almost impossible. (A rumour was subsequently put about that a concrete core lay beneath 2½ inches of timber, but there is no truth whatever in this).

After this martyrdom in the cause of the Hospital the Germ was stationed behind the West Wing where the Depression he had presaged overtook him with the rest of us that same autumn. One other foray he enjoyed just before his eclipse. Very early one morning certain members of the House decided to show him the view from the roof of the Surgical Block. With enormous difficulty he was introduced into the lift on the ground floor. The gates were closed, the fifth floor button pressed, and the lift descended to the basement with a bang. The escorting party managed to get him out of the lift again, up the stairs and back to the place where he was to stand gazing across at the clinical lecture theatre for the next six years.

The year 1945 found the creature still intact and unchanged apart from the patina that camouflages all the neglected treasures of Bart's. By now it was nameless, referred to simply as "the monster". But on VJ night, 1945, when the war ended, the dumb forgotten effigy rose to sudden fame. As thousands of Londoners poured through the empty evening streets, drawn by the strange exhilaration of relief and gratitude to the home of their King, Percy was lifted on to a trolley and escorted westwards up the Strand. His great white eyes goggling with excitement, he swept across Trafalgar Square in the gathering dusk and on to Piccadilly for a quick tour of the Circus. Passing some road works en route, Percy continued his progress with a red lantern swinging from his patrician nose. Slowly he edged along the Mall until he was amongst the crowds at the palace gates. There he stood for his finest hour, etched black against the floodlit building, great tears of pride rolling unseen down his war-stained cheeks, and bearing on his head a gentleman of this Hospital in a tall hat who directed and conducted the singing of the crowds. An unforgettable sight. As the evening and the songs wore on, Percy was moved along by pygmy constables and brought safely home.

His career as a tribal god had begun. He was transferred to Charterhouse and the next few years saw him presiding over many battles in his honour. Yet one notable insult he suffered within the City itself. Already allowed to pay his tribute to royalty, he tried to attend the procession of a Lord Mayor. But civic dignity proved too austere for such student pranks and he became the centre of a considerable struggle in the vicinity of Ludgate Circus, from which he emerged in a damaged condition. Since then Percy has gone into a decline. After losing his head, his feet became disarticulated and he now exists as various parts. The head is most

often used as a portable talisman of the whole, and as such it has travelled widely between the City, the Borough, and Whitechapel. Even the massive trunk was recently borrowed for alien rites across the river and tored and honourably retired. He might even be sent to fulfil a greater destiny at the headquarters of UNO where his black, exophthalmic, prognathous presence, in all its saturnine, achondroplasic, onychogry-



Percy . . . . his black, exophthalmic, prognathous presence . . . .

the recovery of these items was fully described in the March issue of this JOURNAL.

It seems a pity that the present custodians are content with these relics of their traditional idol. Perhaps he could be fully restphotic glory would preside at their councils as a haunting concept of Post-Irradiation Man.

(The photographs are reproduced by kind permission of Colonel Dove.)

FLASHBACKS TO THE 1890'S

by PENRY W. ROWLAND

THE HONORARY Staff at St. Bartholomew's Hospital towards the end of the nineteenth century, exhibited all the experienced dignity of the late Victorian age. The pace was set by the high-stepping pairs in their broughams, the standard by the cockaded top hats of their coachmen.

During the ward rounds and at surgical consultations the unruffled calm was occasionally broken. Unfortunately, it is not easy to recover the atmosphere of quiet assurance, the kind avuncular attitude to the students, the graciousness of the dealings with sisters and nurses and the friendly interest in the often grubby Victorian patients.

Physicians were beginning to yield pride of place before the daring of surgeons — a tendency hastened by the South African War and still more by the two World Wars.

Besides these tragic opportunities, antiseptics, beginning with the crudeness of the carbolic spray and followed necessarily by the rigours of asepsis, made the going easier for surgeons and safer for their patients.

The physicians, on the other hand, had to traverse the long darkness which preceded the antibiotic dawn and the showers of polysyllabic drugs which continue to fall on the medical and surgical sides alike.

It was indeed quite time that the whole medical profession accelerated its lumbering progress, and this century has seen the 'general advance'.

There were reasons for radical medical revision in hospital and nursing regime in the recurring shocks, e.g. when judge and jury in the typhus age shared in the death penalty with the condemned in the stagnant air of the crowded court — the lesson was only half learned. Again, when the physicians sent to South Africa reported of the tragedies of typhoid in overfilled wards; and again in the appalling death-rate amongst the children to whom our young troops had carried Rubeola. The lack of inherited and acquired immunity was not the only factor, for the patients compelled to lie on mattresses in the hospital grounds recovered quickly and had few complications, but the Army Medical Authorities did not broaden their methods, and hospital boards at home had no experience of the personal disaster.

This is illustrated by the facts of the Influenza epidemic in 1918, when the weary soldiers were packed almost bed to bed here, in England, and the mortality was pitiful — and shared by the nurses and ward staffs.

Still the old deadly phrases are repeated in these well informed times, "Keep him warm, avoid draughts, keep the windows closed, put on more blankets, keep the fires up all night" —the lessons are slowly learned.

A few flash-backs to give glimpses of the men who led the profession during the last years of Queen Victoria's reign might help one to visualize the changes which were taking place sixty years ago.

The precedence given to the medical side of the profession is threatened by the pathologists, who are in the front line of advance.

It is said that in some countries armchair diagnosis is becoming popular and personal contact with the patient more and more rare —Television, when the display is of report after report from Pathologists, Radiologists and Chemist is much less human and enjoyable than the old personal relationship.

* * *

Tom Smith was surgeon to the P of W who had hurt his knee, the patella being torn across. The old surgeon put on a back splint and bandaged it neatly into place. News of the treatment got around, and when Lockwood was asked in general terms about the bandage treatment of fractured patella he condemned it thoroughly.

Tom Smith was vexed, but a few weeks later had a useful "guinea pig" in the form of an old lady. This old dear had had a Sunday chatter-party with three neighbours and on their departure placed her delicate old porcelain on a tray to take downstairs to wash and put into safety.

As she ventured on the first stair she

stumbled, and in the effort to steady herself sat down violently, with the tray undisturbed across her knees, helpless. She is said to have sat there for two hours. She was admitted to hospital under Sir Thomas Smith.

While he was confirming the diagnosis of fractured patellae he said to his house surgeon, " Send across and tell young Lockwood I want his opinion on a case ". He came, rubbing his hands, well pleased with the honour.

" Good morning, Lockwood ! I hear you have been criticizing my treatment of an old patient of mine who is a V.I.P. I know his constitution through and through and chose appropriate treatment. Now this old lady has broken both kneecaps. I will treat the worse side as I treated my recent patient, and you can do whatever you like with the other side. We will meet again in a month to see the results. Agreed ? "

" Yes Sir ".

After Lockwood's departure Tom Smith called for a wooden back-splint and a couple of bandages, and applied them.

Lockwood made preparations for two days later. Finger chips were taken from all taking part, and the skin over the patient's knee. The perspiring surgeon wired the patella with his usual exactness.

A month later the two surgeons and their " tails " met at the bedside. Splints and dressings were removed and the old dear got up trembling and walked past three beds. Then she gracefully thanked both surgeons, who were pleased with the results, and shook hands. Even the ranks of rival firms " could scarce forbear to cheer ".

When Tom Smith at last accepted his Knighthood from Queen Victoria a pleased crowd turned up at Surgical Consultations and cheered him as he entered the semicircle. He put up his hand for silence and said, " Gentlemen, I can't help knowing what all this noise is about. Her Gracious Majesty has been pleased to honour our beloved Hospital, and I happened to be in the position to have the honour of accepting it at her hands ". Suddenly he turned to the crowd again and said, " Boys, in spite of this occasion I want you always to think of me as Tom Smith ".

He had his greatness " thrust upon him ".

A short time afterward in another hospital the senior member of the staff was knighted. The house surgeon with a piece of perishable chalk carefully marked ' Sir J.' on the staff board and glided into the shadow just in time to see the new knight stop, insert a monocle, puff out his chest and emit a longdrawn " Aaaah ". He had achieved greatness.

A fortnight before, this surgeon had stalked into the theatre where the makers had arranged for an expert to demonstrate the use of the new cystoscope. A few minutes later he came forward to inspect the bladder. After a minute or two he said, " As I expected, I see nothing beyond a little cystitis, but it is a bit cloudy ". " You will see more clearly, Sir, when I have connected it up with the battery ! "

To complete the triptych one suggests that Sir James Paget was " born great ".

* * *

Howard Marsh had a special interest in joints and showed a patient whose knee joint he had immobilized, but who had been persuaded to have her knee " manipulated ". Apparently the treatment had caused an acute recrudescence of the disease and Mr. Marsh's ire. There were many such tragedies of treatment before X-rays put a brake on those crude and often untrained enthusiasts.

* * *

On the pathological side the hospital was fortunate to have Professor Klein, a very modest man with a fine investigating mind. It is said that as a boy in Vienna he was fascinated when observing the process of ' manufacturing ' Pate de Fois Gras. Indian corn was rammed down the forcibly extended gullets of geese with a bamboo rod until the limit was reached—twice daily ! The metamorphosis of corn into fat intrigued him and enticed him to his future career.

As he passed along his class with their eyes close to their microscopes a student asked, " Professor, why do cats' eyes shine in the dark ? "

" Not in the dark, my boy, not in the dark ! . . . I don't know. I will try to find out ".

The following week, transverse sections of the fundi of cats' eyes were distributed and careful diagrams were beautifully chalked on the blackboard to show the mucus cell layer.

One pictured distraught owners of cats in his home area calling vainly for ' Tibby ' that week.

James Berry was performing an early thyroidectomy, and amongst the students watching was one from " the States ". A neat performance, efficiently carried out. A student turns to the visitor and says, " That was a nice piece of work, pretty fast, too ".

" You call that fast. Why, we've an operator in Cincinatti who could do it in half the the time ".

" A case of hyperthyroidism, I suppose ", says the student.

" No ! No ! Simple Tumor ".

" I meant the Surgeon, not the patient—tachycardia, tremors, sweating and all that ".

Operations are only rarely the better for speed. At the Evelima Hospital one Saturday, a year-old patient was admitted twelve hours after the onset of an intussusception. The surgeon on duty was Tubby ; a phone query revealed the fact that he had left and was calling in 20 minutes in a hansom to pick up one of the housemen and take him to the Rugby Final. The patient was prepared, on the table and anaesthetized when the cab clattered up.

" Sorry. I'm off for the Final ".

" So I understand, and you are taking my colleague, but I must ask you to operate on an emergency first ! Everything is ready and it won't take you five minutes ". And it didn't. Confirmation by palpation, incision, return by manipulation.

" Right ! Carry on, anaesthetist ! You may sew up ! Goodbye ! "

Three hours later the Houseman hears the surgeon return, and calls out " Who won, Sir ? "

" Wales ! A goal and two tries ".

" Good ! By the way, the patient is all right, Sir ! "

And that blessed infant went down with Varicella a week later !

* * *

Tom Smith and Willett and Langton had examined a rectal case in Consultations and Walsham was quietly examining when his whole hand disappeared. Tom Smith whispered to his H.S. " After your chief, my boy, we must not let him go ! " When the patient had been wheeled out Walsham was asked for his opinion in his turn, and calmly said " The growth is operable. I find the mucous membrane quite healthy above it ". Tom Smith walked up to him, apologized handsomely and then turned to the rows of students and apologized to them also for his " ungentlemanly " whisper.

* * *

A butcher was rushed in from Smithfield with a badly cut arm, cut he said, by a hard-frozen leg of a New Zealand lamb. The artery was soon found and tied and stitches were about to be inserted when the patient refused to be treated by anyone but ' Butcher Walsham's son '. He drove down from the West End and did the stitching himself with his unfailing neatness.

Walsham prepared some of the intricate anatomical dissections that used to be in the Museum.

* * *

On operating day Bruce Clark was informed that a few American doctors were going to watch him operate. He was vexed and had a talk with his H.S. in the Square. Half an hour later he was introduced to the doctors and entertainingly distracted them while he washed up. Quietly the anaesthetised patient was wheeled in and the H.S. put the towels in place, the limbs in lithotomy position, and inserted the " staff ". Then he quietly said " Ready, Sir ".

Bruce Clarke still holding the visitors in conversation walked a few steps to the table, his bulky H.S. closed in behind him. Continuing his narrative the Surgeon picks up the placed scalpel, runs it along the staff, inserts his finger and entices out a goodly calculus, still carrying on his talk. The H.S. plugged the wound, nodded to the porters who wheeled the patient into the anaesthetic room where two or three vessels were tied, and the dressing applied.

One of the visitors calls out to the Surgeon who is beginning to wash his hands, " Say doc ! Are you going to operate on that man ? "

Bruce Clarke turns to the Theatre Nurse, " Will you please hand me the specimen bowl, sister " and demonstrates the main points of the calculus.

No allusion was made to the operation, and there is an unusual dearth of wisecracks for several minutes !

* * *

An inquisitive student notices Greybeards

making their way in small groups to the old Anatomical Theatre. He shyly follows them when he is overtaken by a striding forceful man, cloaked and with his arms clutching unknown objects. " Is this where the meeting of the Anatomical Society is to be held ?"

" Yes Sir, I'll show you ".

" And what, may I ask, are YOU doing here ? "

" I'm just inquisitive Sir ".

" Come in with me, then, I have something to show them," and side by side they sat five or six rows from the floor of the arena

Sir James Paget had just began his speech. His stance, his dignity, his voice and elocution, combined to form delightful background for his oratory. After a dull five minutes of mumbling among the experts there was a brief pause. The stranger turned to the student and said " Watch ! I am going to try to wake them up ". He stumped down the steep gangway and from the shelter of his cloak delivered four skulls which he placed upon the table. He then gave a graphic history of each. They had all been trephined with flint implements ' to let out evil spirits '.

The demonstrator was Professor Haddon of New Guinea—an anthropologist of great repute. The somewhat somnolent audience ' sat up and took notice ' and Sir James Paget welcomed the speaker and praised handsomely his ethnological reports from New Guinea.

Many years later the writer ventured up the Baltic on a Finnish boat containing Danes, Swedes, Russians and Finns hastening home. At Copenhagen four men joined the boat. They had been attending a conference on ethnology in Denmark, which had come to an abrupt conclusion. One of them was an old professor who joined the little group of British as he wished to polish up his English. When he told of his long residence in New Guinea he was asked if he knew Professor Haddon.

" Yes, I knew him well. He was my nearest neighbour in New Guinea and a good friend. We two met every Christmas after several days of difficult journeyings through forests and over mountains ".

" And how did you like the New Guinea head hunters, Sir ? "

" They were my very dear friends. I lived with them for years ".

He was Professor Gunnar of the Helsinki University. He opened the Turku museum for us at 7 a.m., turning the caretaker out of bed to do so. The professor and his family suffered grievously during the war which began that week.

* * *

Early in the Boer War, before the City Imperial Volunteers went out after a service in St. Bartholomew's the Great, Dr. Herringham's H.P. was used as an outsize guinea pig for an experimental dose of antityphoid serum. He had a very striking reaction to an enormous dosage and was looked at by several of the senior staff.

* * *

Professor Koch of Germany was invited to address a " hand picked " crowd at Queen's Hall. A student passing by thought the meeting would be of prime interest so he walked up the steps with the invited guests. Having no ticket he was firmly refused admission but found that the delegates were coming from the Albert Hall and hastened across and enquired, " Have any delegates failed to turn up ? "

" Well, we have just had a telegram to say that a Russian delegate cannot get here. Here is his ticket. Baron Rumanwiski ".

" Thank you. That will do well " and back he hurries to the meeting.

" I thought we made it plain that only delegates were admitted ".

The Baron's card is handed to the keeper of the door, who said, " I don't think you look the part, young man ".

" Oh, that is because I've left my sable coat at the Albert Hall ". He entered and was challenged by Horton Smith Hartley, the organiser. " How did you get in ? "

" I'm Baron Rumanwiski, Sir, for this occasion only ! "

The packed hall gave an unmistakeable impression of frank unbelief. It must be confessed that the press was pretty well united in scoffing at the great discovery, and one paper produced a cartoon showing a row of dead bed patients as the professor walked down the ward carrying an enormous syringe.

A House Surgeon, T. P. Legg, from Yorkshire, dictated a note to his South Country dresser in Out-Patients, "An incision was made and a little cream coloured puss escaped".

Of a book—Edward and Ballance—word was passed round that Ballance supplied the letterpress and Edwards supplied the balance.

A new patient calls to her neighbour, "I say, missus. They've written 'C. of E.' on the board over my bed. Can you tell me what it means?" "Oh yes, I was puzzled at first, but I found out that it means 'Case of Emergency'; but I had my op, and they haven't crossed it out yet!"

The whole of England's press was watching the final days of Gladstone. In the daily bulletin it was said "The doctor says the patient is suffering from 'change stroke breathing' and that this is looked upon as a serious symptom". This was reported to Sir Dyce Duckworth, who crinkled his eyes with the prospect of telling his friend Cheyne-Stokes. He turns to one of his clerks and asks him what he knows of Cheyne-Stokes. He stammers out "Dr Cheyne was a Guy's man and Stokes a professor at Dublin, I think". "Something else to tell my friend, he will be pleased". A back row student whispers to his neighbour "A case of Schizophrenia?" "I don't know what that means but I think 'Doublin' is the key word here!"

ABERNETHIAN SOCIETY

Elections

At a meeting of the Society, the following Officers and Committee were elected for Michaelmas 1957.

President: C. G. Stevenson.
Secretary: J. Hedley-Whyte
Treasurer: J. D. Parkes
Committee:
Miss J. Angell James
J. T. Silverstone
J. S. Price
D. J. Tooby

Programme

Thursday, October 3. Inaugural talk
"From Trade Guild to Royal College"
Prof. Sir James Paterson Ross, K.C.V.O., M.S., P.R.C.S., F.A.C.S.
The Great Hall at 4.45 p.m.

Thursday, October 24
"Medical Education and Cancer"
Mr. Malcolm Donaldson, M.B., B.Ch., F.R.C.S., F.R.C.O.G.
Physiology Theatre, Charterhouse, at 5.45 p.m.

Thursday, November 7
"Our Victorian Architecture"
Mr. John Betjeman
This talk will be illustrated by a 'magic lantern' show.
Physiology Theatre, Charterhouse, at 5.45 p.m.

Thursday, November 14
Last day of nomination of Officers for the next Session of the Society.

Tuesday, November 19
"The New Organization of the Royal Army Medical Corps"
Lieut.-Gen. Sir Alexander Drummond, K.B.E., C.B., Q.H.S., F.R.C.S., D.L.O., Director-General Army Medical Services.
Physiology Theatre, Charterhouse, at 5.45 p.m.
Election of Officers for the Lent 1958 Session of the Society will take place at this meeting.

Tuesday, December 3
Show of films of medical and general interest. Titles to be announced.
Physiology Theatre, Charterhouse, at 5.45 p.m.

Thursday, January 9
"Some Medical Aspects of the Rites of Indian Fakirs"
Dr. John Hunt, D.M., M.R.C.P.
This talk will be accompanied by exhibits.
Physiology Theatre, Charterhouse, at 5.45 p.m.
Visitors are welcome at the Society's meetings.

SOME THOUGHTS ON THE PRESENT TREATMENT OF METASTATIC BREAST CANCER

by G. J. HADFIELD

IN A FIELD like clinical cancer research where fresh observations are constantly being made, the assertions of yesterday often become discarded to-day. Hard and fast rules and plans are therefore impossible. We would preface these remarks by saying that what we are about to describe to you is an outline of the present plan of work carried out in this hospital on patients with metastatic breast cancer by the Surgical and Medical Units and the Department of Neurosurgery. It could perhaps be called a scientific enquiry with the reservation that the methods employed must benefit and give relief to the patient as their primary object. If, however, by these methods we can learn more about the growth and control of metastatic breast cancer in the patient, then we have not only obtained relief for one case but have also been able to obtain valuable data which might otherwise have been lost.

Hormone treatment of metastatic breast cancer may be either Additive or Ablative. Such alterations to the environment of a hormone sensitive tumour may cause either an increase or decrease in the rate of growth. Our main interest has been in the field of hormone deprivation and at the moment particularly to study the efficacy of surgical hypophysectomy, and to ascertain the criteria on which selection for this operation can be assessed.

The phases that a patient with metastases goes through may be summarised as follows:

i. Pre-operative evaluation and decision as to course of treatment.
ii. Surgical hypophysectomy.
iii. Post-operative evaluation.
iv. Out-patient follow-up.

From this you can appreciate that the project is a team effort.

The patient is first admitted to the general medical or surgical wards for a preliminary evaluation. A complete history is taken and a thorough physical examination followed by special tests and X-rays is done. All dates are not only related to the patient's actual age in years but also to the patient's menopausal age whether natural or surgical. Relation of tumour growth and the appearance of metastases to this time is of considerable prognostic importance.

The sites and type of all metastases are carefully noted. Cases with gross disease who are already moribund are not considered suitable for treatment by surgical deprivation. The sensitivity to hormone changes varies considerably with the site of metastases. In our experience good results have been obtained with local skin recurrences, metastases to lymph glands, bones, the other breast, and discrete islands of growth in the lungs. Secondary deposits in the liver, brain, peritoneal cavity and pleural sac and widespread disease of the lung parenchyma are rarely materially influenced by hormone deprivation and so we do not think that at present hypophysectomy is indicated in these circumstances.

Careful evaluation of the patient's general condition is important, for the very old or the very sick an operation of this sort would seem inadvisable.

The results from other types of surgical deprivation are of the greatest importance. Cases that have obtained relief from either a naturally occurring menopause or a surgical castration will often respond favourably to hypophysectomy. The same is true for cases that have obtained remission from adrenalectomy and have reverted to exacerbation of the growth and symptoms. Failure however to respond to castration with or without adrenalectomy in no way precludes a case from hypophysectomy. Perhaps this can best be explained by showing how the rationale for hypophysectomy has become built up.

The concept of simple oestrogen dependence is now thought not to be the complete

story for the following reasons.

Firstly, regressions induced by removal of oestrogen sources, such as adrenals and ovaries, can be followed by exacerbation of the disease, in the absence of any significant quantity of oestrogen demonstrable in the urine or on vaginal smear. Hypophysectomy in these cases will often cause regression.

Secondly, Pearson of Memorial Center, New York[1] showed that a breast cancer in regression following hypophysectomy could be activated by administration growth hormone preparations.

Thirdly, it has been shown by Scowen and Hadfield[2] that other factors present in the urine of the normal pre-menopausal woman and removed by hypophysectomy can stimulate breast growth. These substances are non-oestrogenic. Much effort has recently been expended in attempts to find the exact identity of this pituitary factor. At present we think it safest to call it simply and rather non-committally the *Pituitary Mammotrophic Principle*[3].

Lastly, further evidence is provided by studying the natural history of the disease in relation to the menopause[4]. A comparison of the lengths of remission obtained by the naturally occurring menopause and surgical castration is striking. The former can induce remission for periods of 1-4 years, compared with the latter where the average duration of remission is of 3-12 months. To what then is the difference due ? We believe that apart from withdrawal of ovarian function at the time of menopause there are at the same time parallel pituitary changes. Thus the patient temporarily loses the ovarian oestrogen and pituitary mammotrophic stimulus. With the simple castration only, the so called "castration effect" is much shorter than in the natural menopause.

Estimation of the patient's oestrogen level can be done in one of two ways, either by examination of vaginal smears or by a complex chemical extraction method on a 24-hour sample of the patient's urine. Parallel studies show the first and simple method to be reliable[6]. • The second method although more accurate, is in fact a research tool.

Normal menstruating women on admission for evaluation are assumed to have a high oestrogen level and no estimations are done on them. This is really only to save time and trouble because a complete month of serial readings on the urine would be required to give a true picture of the patient's oestrogen level.

In the post-menopausal or castrated case a series of five 24-hour specimens of urine (one reading being obtained from each specimen) gives a good idea of the oestrogen level pre- and post-operatively. The post-operative specimens are usually collected 10-14 days after the operation so as to avoid false readings which occur due to temporary elevation of oestrogen levels forming part of the general adaptation syndrome in the post-operative period.

Further samples are collected at home in the 24 hours immediately prior to an out-patient visit by the patient. By this means the patient's oestrogen studies and clinical picture can be correlated. The availability of polythene winchesters and funnels removes many of the problems and inconveniences of home collection of specimens.

Recently a further project has been started to study the fluctuations in the mammotrophic factor with hypophysectomy. For this a further 24-hour specimen of urine is collected. From this the non-oestrogenic residue which contains the mammotrophic factor is extracted. Its quantity and presence is gauged by noting its effect of stimulating the simplest possible breast structure, that of the male hypophysectomised weanling mouse. Hypophysectomy in the patient abolishes the presence of this factor, but its pre-operative level varies. The quantity of this for any given case may help to forecast the efficacy of hypophysectomy.

The levels of calcium in the blood and urine give an idea of the rate of bone destruction in osteolytic metastases and comparison of serial observations gives an idea of the course of the disease in bone.

To gauge clinical results it is essential for us to know whether the pituitary gland has been totally removed. One of the most sensitive indicators of this is a change in thyroid function. Total pituitary removal will give a complete cessation of thyroid function requiring supportive therapy. It can be clearly shown by pre- and post-operative studies on serum protein-bound iodine.

Ketosteroid estimations are being performed routinely with all cases but their correlation with the progress of the disease, if any, is difficult to interpret.

Changes in the size of ulcers or skin lesions is recorded by colour photography on 35 mm. slides. This we think is superior to

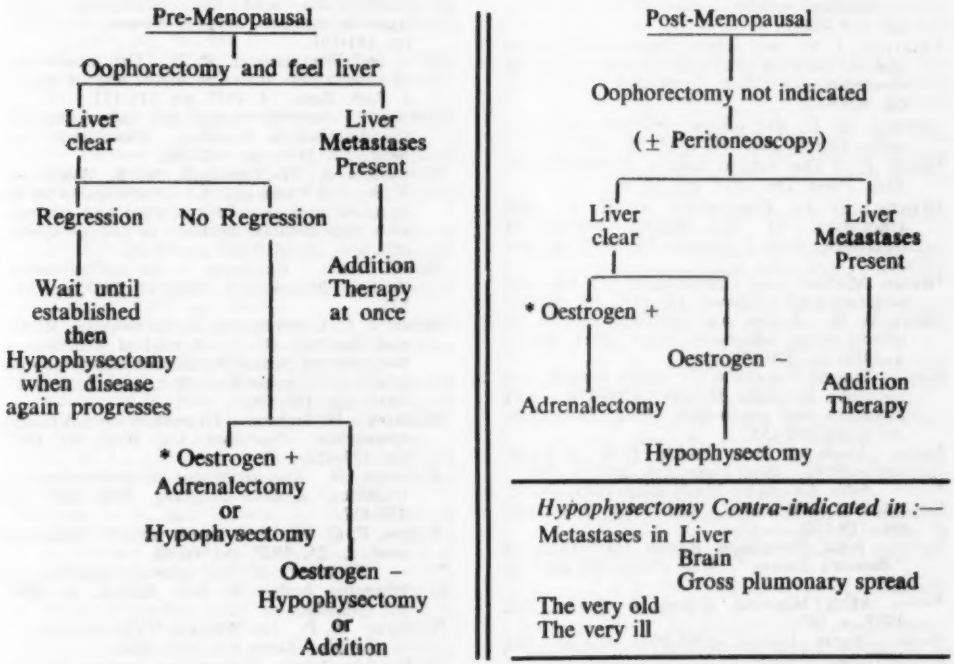
the written word or simple measurement with a ruler alone, although these are included as well.

It seems certain that simple oestrogen sensitivity is not the only hormone factor in maintaining breast cancer. It may be that it is a combination of this and the pituitary factor but further studies are needed before we can say this.

To carry out a project of this sort it is essential to have a team as no one can be a specialist in every part of the work. Each month a meeting is called and the clinicians and chemists meet to discuss their work, presenting their own sides of the story and trying to correlate them into one complete picture. In this way new cases are evaluated and old ones followed up.

In conclusion we would like to summarise our general views on the treatment of the patient with metastatic breast cancer. This we think can best be done by the following diagram :

Scheme for Hormone Treatment in Metastatic Breast Cancer



* In the present series these are also being subjected to hypophysectomy.

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*——. *See also* FRANCIS, G. E., and ——.

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SPORTS NEWS

VIEWPOINT

Another club is to be launched at Bart's, this time for the benefit of those fortunate enough to own cars or some form of mechanised transport. The Motor Club sets out to provide organized activities in the form of rallies, treasure hunts, etc., and as such will provide for the specialized wants of those for whom this sport appeals.

During the past season, one member of the Rugby Club must have set a record for playing rugby in various countries. He now joins the select few who have played behind the Iron Curtain and returned intact. The other matches were played in Italy, Roumania and France. Altogether quite an imposing record, and one which any player in the Rugby Union, let alone a student, would be happy to equal.

Many secretaries are at the moment anxiously looking to the October Clinical intake to replace those of previous years who have now qualified. It is thus impossible to assess the strengths of the various clubs at this stage, though the Rugby Club seem at the moment to be most in need.

CRICKET

RESULTS OF 1957 SEASON

Played 26 Won 11 Drawn 8 Lost 7

1st XI v. Henfield.

Played at Henfield on 17th August, 1957 and won by 4 wickets.

This match was a welcome resumption of an old fixture and resulted in an excellent social occasion. The Hospital fielded first, assisted by some former Bart's players and dismissed Henfield for 83. The necessary runs were scored for the loss of 6 wickets, although at one stage the score was 31 for 5.

Henfield 83 (P. Harrison 4–11, A. Garrod 3–19).

Bart's 84 for 6 wickets (A. Whitworth, not out 33) (P. Drinkwater 22).

1st. XI v. Bromley.

Played at Bromley on 18th August, 1957. Match drawn.

Unfortunately heavy rain postponed the start of this match, the final fixture of the season. The Hospital batted first on a slow and damp wicket and batted consistently to score 153 for 8 wickets. J. Nichols made a welcome re-appearance for the team and batted attractively for 47. Some brave blows by the tail improved the score, and Bromley were thus left to score 153 in 2 hours. They opened confidently, but the fall of some quick wickets put them behind the clock and at close of play had made 106 for 9 wickets. Garrod and Nichols both bowled very well on an unhelpful wicket, and Garrod ended the season appropriately enough with a wickt off the last ball of the match.

Bart's 153 for 8 declared (J. B. Nichols 47, R. J. Mitchell 28, D. Richards, not out, 26).

Bromley 106 for 9 (D. L. Rigby 60; A. Garrod 6–54, J. Nichols 3–33).

BOOK REVIEWS

TECHNIQUE OF FLUID BALANCE *by* Geoffrey H. Tovey, M.D. Oliver & Boyd, Edinburgh. pp. 90. 12s. 6d.

There have been a number of books on the management of salt and water metabolism. This monograph is shorter than most and for this reason alone can be recommended to the busy student. The price is 12s. 6d. The main difference between this book and those which have appeared before is an attempt to be less dependent on laboratory results. Not everywhere are there facilities to give the practising physician reliable results of chemical estimations quickly and Dr. Tovey aims to guide the reader in drawing practical conclusions from the interpretation of the patient's history and clinical state only. There are numerous useful tables.

The Specimen Fluid Balance Charts are excellent and well deserve copying. The book is very fully indexed — some 200 items for a book of 90 pages. This should result in its being used not only as a textbook but also as a practical manual on the ward.

In a future edition which will undoubtedly be demanded it may be advisable to make clear that a Fantus test should preferably be done on a 24-hour specimen of urine, and that the haematocrit as well as the haemoglobin level is a useful measure of haemoconcentration, particularly in hypochromic anaemia.

On page 24, the last two sentences on the parenteral treatment with potassium salts will make sense if they are reversed. On page 69, the reader might think that citrate (the sodium salt rather than the potassium salt) is given to produce diuresis during sulphonamide treatment, whereas in fact the purpose of giving citrate is to maintain the urine at an alkaline pH.

The description of the treatment of tubular necrosis might well be reconsidered. The author discusses the "diuretic phase" of acute tubular necrosis as if it were part of the natural course of the condition. However, a diuretic phase should never arise if his excellent advice is followed on avoiding overhydration during the oliguric stage. Peanut oil as a source of calories is now being superseded by glucose as the sole provider of energy with vitamins added. Ommision of peanut oil reduces the tendency to vomit. Nevertheless when this occurs the vomit should be returned through the intestinal tube as pointed out on page 75 where in the next edition it might be mentioned that this requires a previous filtering through muslin. The necessity of adding heparin to the intravenous hypertonic glucose administered through a polythene tube is not emphasized. Presumably this is so because the author recommends elsewhere (page 88) heparin in all intravenous infusions, advice which most authorities would consider as going too far.

H. LEHMANN

TEXTBOOK OF HUMAN ANATOMY. *By* J. D. Boyd, Sir Wilfred E. Le Gros Clark, W. J. Hamilton, J. M. Yoffey, Sir Solly Zuckerman and the late A. B. Appleton. Edited by W. J. Hamilton. London: MacMillan & Co. Ltd. 1956. 1,022 pages; 797 figures; price £5.

The appearance of a new major textbook of anatomy in the English language is clearly a matter of interest for students and teachers alike. The preface begins with a rhetorical question — Is there need for yet another textbook of anatomy? The authors believe the answer to be in the affirmative, and advance three main reasons: first, that progressive expansion of the medical curriculum makes it essential to reduce the amount of factual knowledge which the medical student need acquire; second, that a need exists for closer correlation between structure and function; and, third, that the medical student should be introduced to the wider biological implications of his anatomical studies. Without doubt, most teachers of anatomy will recognise the laudability of all these precepts, and have indeed given effect to their recognition by the changes which have marked the teaching of their subject, particularly during the last ten years. Far less topographical detail is now required of the student, and more teaching emphasis is placed on general biological principles and on the functional implications of structure. Yet, it is true to say that these changes in the climate of teaching have not yet been reflected fully in current major textbooks. The new work now incorporates such changes in approach, and the results are rather diverse.

On the credit side, the book has many commendable features. In dealing with the respiratory system Professor Yoffey includes a good account of the speech mechanism—long overdue in textbooks of anatomy. The segmental anatomy of the bronchial tree is extremely well described and figured. The section on ductless glands makes clear and interesting reading, and it is the more regrettable therefore, that topographical detail has been pared therein to so low a minimum. The central nervous system is excellently described by Sir Wilfred Le Gros Clark, and the whole of this section is enhanced by reference to human clinical disorders.

It is disappointing, even remembering that this is a first edition, that so many errors mar both diagrams and text. The description of the anal musculature, for example, is one now generally recognised as incorrect; the accounts of the lymphatic drainage of the breast given in two sections of the book differ radically from each other; the insertion of the trapezius muscle is both wrongly described and incorrectly depicted; figures 86 and 718 show the superficial inguinal ring in a position which bears no relation to actuality, and the text description is also misleading. It is particularly unfortunate that the

cremaster muscle is described as drawing the testicle, "into the superficial inguinal ring," in view of the criticisms recently levelled at anatomists on this very issue, by a London surgeon. It would appear that he had, after all perhaps, some ground for complaint! It would be tedious and unnecessary to list all the mistakes in the book; one can hope that they will be corrected in a subsequent edition.

The least commendable section of the book is that dealing with the locomotor apparatus. Here, surely, one would expect abundant evidence of that integration of structure and function so rightly lauded by the authors, but this hope alas, proves unfounded. It is only fair to add that many of the defects exhibited in this section are probably due to the untimely death of its principal author.

Inevitably, the altered emphasis in approach has, because of the limitations of space, resulted in the exclusion of a great deal of topographical detail. It may be that this is the greatest defect of the new textbook. Reduction of detail is already accomplished, both in teaching and in the several anatomical synopses available to the student for revision: the wisdom of attempting a comparable reduction within the covers of a large textbook, however, is more debatable. Apart from the natural differences of opinion concerning what constitutes irrelevant topographical detail, the student obviously requires, for both preclinical and clinical use, an authoritative reference book the content of which must be sufficiently ample to meet his varied needs. It is pertinent to ask whether he will or can afford two major treatises on anatomy, or whether, possessing them, he will be able to find the time and the opportunity to make effective use of two such books. The undoubted advantages of the new textbook may well be outweighed by such considerations.

MICHAEL J. BLUNT.

BOOKS RECEIVED

Inclusion in this column does not preclude review at a later date

A SYNOPSIS OF OTORHINOLARYNGOLOGY *by* J. F. Simpson, I. G. Robin, J. C. Ballantyne; John Wright & Sons Ltd., Bristol, pp. 455, 42/-.

SURGERY, PRINCIPLES AND PRACTISE *by* Allen, Harkins, Moyer, Rhoads, with 26 contributors, Pitman Medical Publishing Co. Ltd., pp. xxii + 1495, £5 10s.

ANATOMIES OF PAIN *by* K. D. Keele, Blackwell Scientific Publications, Oxford, pp. x + 206, 27/6d.

CLINICAL PATHOLOGY DATA *by* C. J. Dickinson, Blackwell Scientific Publications, Oxford, pp. xvii + 91, 20/-.

AIDS TO OSTEOLOGY *by* Nils L. Eckhoff and J. Joseph, VIth Edition, Baillière, Tindall & Cox, pp. 193, 10/6d.

EVERYDAY PAEDIATRICS *by* B. Gans and L. I. Norman, Faber & Faber, pp. 216, 12/6d.

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